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A WEEKLY JOURNAL OF MEDICINE AND SURGERY.

J. W. HOLLAND, A.M., M.D.,
H. A. COTTELL, M.D., } Editors.

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* See note p. 64, Profs. Van Buren & Keyes, on Urinary Organs.

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LOUISVILLE MEDICAL NEWS.

"NEC TENUI PENNÂ."

Vol. XIII. LOUISVILLE, FEBRUARY 18, 1882. No. 7.

J. W. HOLLAND, A. M., M. D., ... } Editors.
H. A. COTTELL, M.D., ... }

FIBRINOUS CAST OF THE BRONCHI.

The opportunity is given to but few observers to study personally any considerable number of cases of plastic bronchitis. Able monographs have been written on it based generally upon cases other than those seen by the writer, and such as have been at different times and in different languages recorded in medical annals.

Dr. Glasgow, of St. Louis, presented to the American Medical Association, in 1879, a valuable paper on this subject. Flint has written upon it. Peacock made a contribution often cited by writers; but the most elaborate inquiries, ranging through the bibliography of medicine back to the time of Galen, have been conducted by Biermer and by Lebert. Riegel, upon the foundation laid by Biermer, has constructed an admirable essay.* To this essay the student must go if he wishes to read what is really worth knowing concerning this rare disease. If the term plastic or croupous bronchitis be limited to those cases in which the inflammatory process has been either confined to the bronchi or has originated there, it must certainly be considered of very infrequent occurrence; so infrequent as to justify the report of but a single case, even if that case be wanting in details of an exceptional character.

The following account, sent by Dr. J. G. Hart, of Murray, Calloway Co., Ky., is all that can be learned concerning the clinical history of the patient who expectorated the specimen exhibited by J. W. Holland, M.D., before the Medico-Chirurgical Society of Louisville:

E. L. M., aged sixty-six, occupation, minister and farmer, about six feet high, was of sanguine temperament. In his youth he was healthy and vigorous, though in later years he has had pneumonia thrice, and from some cause his voice has been hoarse and cracked. On December 13, 1881, he worked most of the day in his socks repairing the top of an old chimney. He was seized with a chill at night, followed by lesser rigors the next morning.

I saw him for the first time on the 17th. He was then sitting up, complaining but little. His temperature was 101½°, pulse 140, respirations 38 to 40. There was but little disposition to cough and no expectoration. The bowels were open, tongue and lips pallid and purplish, although there was no marked dyspnea.

From the 17th to the 23d he remained in about the same condition. I could not discover the slightest difference in either pulse, temperature, or respiration. On the 23d he coughed up several fibrinous casts from one to three inches long, some of them as large as a crow's quill. He had no cough now except when the casts were thrown off, and this was done without much effort. There was no mucus or blood with the casts at any time during his sickness.

Percussion gave negative results. Auscultation indicated occlusion of the bronchi in different parts of both lungs.

From the 23d to the 28th (the date of death) the patient gradually grew worse. Each day indications of an extension of the disease to other parts of the lungs were observed. On the day of his death (28th of December) the fauces and roof of the mouth became covered with a diphtheritic deposit. The mode of death was by asphyxia, although exhaustion had been marked for some hours.

The specimen, preserved in alcohol, is an irregular mass of knotted and twisted tree-like branches, about twenty in number, of an opaque, whitish color, with occasional

* Ziemssen's Cyclopedia, Vol. IV.

blotches of a richer pink. When the cast is unraveled it is seen to be in its largest transverse diameter about one eighth of an inch, irregularly cylindrical in form, growing smaller at each of the bifurcations. Some of the ramifications end in a fine translucent coil not unlike the tendril of a vine. Others more complete show a bulb-like terminus, corresponding to the infundibula of the bronchiole. The entire cast, when straightened out, measures about two inches and a half in length, having many short subdivisions, and, judged by the relative length of the branches according to the rule of Biermer, was probably derived from the lower portion of the lungs. It is solid throughout. It is possible that owing to the condensing effect of the alcohol in which it has been kept the dimensions and consistency have been slightly altered. Making due allowance for this shrinkage, it must be considered as somewhat larger and more perfect than the average specimen as recorded by others. Even when freshly voided it must have been of firm consistency; it is now decidedly so.

Chemically it is found to be fibrinous, as it is insoluble in water or solution of common salt, swelling and becoming translucent when macerated in acetic acid.

Microscopically it is discovered to be of the nature of fibrinous or croupous exudation, laminated and fibrillated, containing in the mesh of fibrillar material white exudation-corpuscles and fusiform cells with and without nuclei, the whole presenting a granular aspect. By teasing, the laminæ can be separated so as to be visible to the naked eye. A trace of the mucous membrane can be discerned in the occasional larger nucleated cells. There is some granular fatty matter, and red blood disks are to be found in portions of it.

Here then the diagnosis is complete. According to Da Costa there are no signs, rational or physical, conclusive of this affection, except the expectoration of fibrinous casts. In all probability acute cases are generally called pneumonia till the cast appears in the sputum. Even then stiff mucous and epithelial matter must be differentiated by the reaction in saline solutions and acetic acid. In the absence of a chronic cough or of any account of recurrence of these casts at intervals we must conclude that Dr. Hart's case is one of the acute variety; a type so rare that when Lebert wrote he could find on record but seventeen well-authenticated cases. Says Riegel, in the article mentioned above: "Its occurrence is so infrequent that even in large hospitals years and decades may pass before a single case of the kind comes under observation."

It would be interesting to the analyst to know more concerning the case—if the previous attacks of pneumonia had been accompanied by fibrinous expectoration; if the chronic hoarseness was due to catarrhal laryngitis, as a predisposition to catarrh has been noted in many cases of bronchial croup; if any members of the same family had been similarly affected, as a disposition to it sometimes "runs in a family."

Dr. Hart's case has some features of an exceptional character. Though the mucous membranes had a bluish cast, yet the respirations were only thirty-eight or forty to the minute, and marked dyspnea was absent up to near the close, when asphyxia became apparent. As a rule, the dyspnea and violent efforts to dislodge the foreign matter by coughing give a stormy aspect to the cases that end fatally. This one, however, must be classed with the rarer series, where the cough is not a prominent or harassing symptom.

Percussion, it is said, gave only negative results, showing that, as is usual, the air-cells were not involved. Riegel considers it a characteristic trait that while upon the one hand the percussion-tone is full and clear, the respiratory murmur, on the other, is absent.

The details of treatment would not be unimportant. What potent remedies failed to check the fatal tendency, and what palliatives gave comfort during its course, are matters well worth noting.

Original.

EMULSIONS.

BY C. LEWIS DIEHL.

Among the many preparations that manufacturers of pharmaceutic specialties have made much capital out of in recent years, emulsions of cod-liver oil take a very prominent place. From the claims set forth in their advertisements—which may be either by label, by circular, or by the personal interview of the manufacturer's agent—one is easily led to believe that not alone superior knowledge and skill are requisite in their production, but also that their successful production is possible only with the aid of expensive machinery and the advantages that are derived from abundant capital and a particularly favored market. Yet nothing is further from the truth; for while it is not disputed that a certain amount of knowledge and skill are required, that machinery is a necessity to the production of emulsions in large quantities, and that capital and a good market are advantageous in a commercial sense, their production requires no more knowledge and not as much skill as does the compounding of most of the prescriptions daily put up in our pharmacies, while all the apparatus necessary are a mortar and pestle and accurate implements of measurement. These, with good, fresh cod-liver oil —which can be obtained without difficulty —make the production of an emulsion as easy an operation as the compounding of the simplest prescription. Moreover, such emulsions possess real advantages over the manufactured article. They are, in the first place, perfect emulsions, which the commercial products in many cases are not. Then being prepared at the time when they are prescribed, they are absolutely fresh; and there is perhaps no class of preparations in which this is more desirable. It is true the manufacturers usually claim that their emulsions keep well; but at the same time they are very careful to recommend that such be kept in a cool place. The truth is that notwithstanding such care the preparations furnished soon undergo change, become unsightly and unfit for use; and if it is further considered that this care in their preservation can not always be observed, and, as a rule, is disregarded both by the wholesaler and retailer, it can not be wondered that manufactured emulsions are often dispensed in a very unsatisfactory condition.

These considerations have suggested to me the propriety of offering some formulas for emulsions, in the hope that in the absence of authoritative formulas physicians may find them of sufficient merit to adopt them in their practice; giving them at the same time the assurance that careful pharmacists following them will succeed as well as I have succeeded in preparing them.

The successful formation of emulsions, whether of fixed or volatile oils, is dependent upon certain rules, well understood by accomplished pharmacists, which when deviated from will invariably embarrass the operator, either by retarding or completely preventing perfect emulsification. These rules are:

1. That the water and gum arabic* shall be in definite and absolute proportion to each other. This proportion is three (3) parts of water to two (2) parts of gum, both by weight.

2. That the relation of oil to gum (and water) shall be definite within certain limits; that is to say, the mucilage formed in the above proportions is capable of perfectly emulsifying a minimum and a maximum proportion of oil. The minimum proportion is two (2) parts of oil to one (1) part of gum; the maximum proportion is four (4) parts of oil to one (1) part of gum.

3. That the trituration of the oil, gum, and water be continued till a perfectly homogenous, milky-white, thick-creamy mixture is formed—i. e. until perfect emulsification takes place—before the addition of a further quantity of water or other liquid.

The thick creamy emulsion obtained, if the above conditions are fulfilled, must be the basis of all perfect emulsions. It will bear dilution to any extent with water, forming mixtures varying, according to the proportion added, from the appearance and consistence of cream to that of very thin milk. Obviously the water may be substituted by solutions of saline compounds, syrups, etc., and this enables the production of the various combinations of cod-liver oil in current use from the above thick-creamy emulsion, which for distinction I shall designate as—

I. *Concentrated Emulsion of Cod-liver Oil.* Take of fresh Norwegian cod-liver oil eight (8) troy ounces; powdered gum arabic, two (2) troy ounces; distilled water, three (3) troy ounces. First weigh the gum into a wedgewood or porcelain mortar, then the

* The writer is well aware that other emulsifying agents have been proposed and are used, but he is satisfied that none of these answer as well as does gum arabic.

oil, and triturate till the gum is well mixed with the oil; then weigh into the mixture the distilled water, and triturate the whole briskly until the mixture thickens and acquires a pasty consistence and milky whiteness. Now scrape down the portions adhering to the sides of the mortar and to the pestle, and continue the trituration for a short time, after which add such other ingredients as may be desirable or transfer the concentrated emulsion to a wide-mouthed bottle for future use.

This concentrated emulsion will keep for a reasonable time in cold weather, and, if placed in the ice-chest, also during warm weather. It may therefore be kept in stock if the demand for emulsions is brisk enough to justify it; but inasmuch as its preparation does not consume more than five or ten minutes, it is advised to always prepare it fresh, or, at all events, never to prepare more than a week's supply, particularly in summer. Its consistence is such that it is poured out of the containing vessel with difficulty; hence the necessity of using one with a wide mouth, which should be as securely stoppered as possible, and should be cleaned very carefully each time it is refilled. All this takes time and involves trouble, which is prevented by preparing the concentrated emulsion only as required.

II. *Simple Emulsion of Cod-liver Oil.* Take of concentrated emulsion of cod-liver oil thirteen (13) troy ounces; oil of wintergreen, twenty-four (24) drops; syrup, one (1) fluid ounce; water, three (3) fluid ounces. Weigh the concentrated emulsion into a mortar, add the oil of wintergreen, and triturate thoroughly; then gradually add first the water and then the syrup.

The manipulation for this emulsion is typical for all the other cod-liver oil emulsions given below. It has the consistence of very thick cream, but is readily poured out of narrow-mouthed bottles, is milky white, and mixes readily with water or other liquids that may be administered with it. It contains exactly fifty per cent (by volume) of oil, the quantity that manufactured emulsions are said to contain, although I have convinced myself that some of them do not contain that proportion. The oil of wintergreen disguises the odor of the cod-liver oil very admirably, and has the further advantage that it acts as a preservative.

III. *Emulsion of Cod-liver Oil with Hypophosphite of Lime.* This differs from the simple emulsion in that one hundred and twenty-eight grains of hypophosphite of calcium are dissolved in the water, each tablespoonful of the finished emulsion containing four grains of that salt.

IV. *Emulsion of Cod-liver Oil with Hypophosphite of Lime and Soda.* This differs from the simple emulsion in that one hundred and twenty-eight grains of hypophosphite of calcium and ninety-six grains of hypophosphite of sodium are dissolved in the water, each tablespoonful of the finished emulsion containing four grains of the calcium and three grains of the sodium salt.

V. *Emulsion of Cod-liver Oil with Hypophosphites.* This differs from the simple emulsion in that one hundred and twenty-eight grains of hypophosphite of calcium, ninety-six grains hypophosphite of sodium, and sixty-four grains of hypophosphite of potassium are dissolved in the water; each tablespoonful containing four grains of the calcium, three grains of the sodium, and two grains of the potassium salt, and corresponding to a teaspoonful of Churchill's syrup of the hypophosphites.

VI. *Emulsion of Cod-liver Oil with Phosphate of Lime.* This differs from the simple emulsion in that two hundred and fifty-six grains of phosphate of calcium are dissolved in the water by the aid of one hundred and twenty-eight grains of hydrochloric acid;* each tablespoonful containing eight grains of the phosphate held in pleasantly-acid solution.

VII. *Emulsion of Cod-liver Oil with Phosphate of Lime and Soda.* This differs from the simple emulsion in that two hundred and fifty-six grains of phosphate of calcium and sixty-four grains of phosphate of sodium are dissolved in the water acidulated with one hundred and twenty-eight grains of hydrochloric acid; each tablespoonful containing eight grains of the calcium and two grains of the sodium salt.

VIII. *Emulsion of Cod-liver Oil with Lactophosphate of Lime.* This differs from the simple emulsion in that two hundred and fifty-six grains of lactate of calcium dissolved in two fluid ounces of diluted phosphoric acid are substituted for two fluid ounces of the water, each tablespoonful containing eight grains of lactate of lime or about ten grains of lactophosphate.

IX. *Emulsion of Cod-liver Oil with Wild-cherry Bark.* This differs from the simple emulsion in that the oil of wintergreen is substituted by eight drops of oil of bitter

*The use of hydrochloric acid instead of phosphoric acid is preferred, because the large quantity of the latter required would make the preparation unpleasantly sour.

almonds, and in that one fluid ounce of the fluid extract of wild-cherry bark is substituted for one fluid ounce of the water; each tablespoonful containing fifteen minims of the fluid extract and one fourth of a drop of oil of bitter almonds.

Other combinations of cod-liver oil with different medicinal agents may be effected in the same way as pointed out in the above, or the proportions of salts may be varied to suit particular cases. The process for the concentrated emulsion also may be applied to the emulsification of other oils, as, for instance, in the following:

X. *Emulsion of Castor Oil.* Take of castor oil four (4) troy ounces; powdered gum arabic, one (1) troy ounce; distilled water, one and one half (1½) troy ounces; syrup, cinnamon water, of each three (3) fluid ounces; spirit of cinnamon, twelve (12) minims. Emulsify the oil with the gum and distilled water as directed under I, then add the other ingredients successively with constant trituration. This emulsion contains thirty-three per cent of castor-oil, and is consequently more limpid than the fifty-per-cent cod-liver oil emulsions above described, and is in every respect an elegant preparation.

LOUISVILLE.

Correspondence.

NEW YORK LETTER.

Editors Louisville Medical News:

Since my last I have by way of recreation taken in a little theology. I went over to the City of Churches last Sunday and heard the renowned Mr. Beecher, and yesterday the celebrated Dr. Talmage. The first preached on the divine government, but did not contend for eternal punishment. He was not certain how the condemned escaped perpetual pain, whether by restoration or redemption, but he could never preach the doctrine of eternal damnation.

Dr. Talmage commenced a series of lectures yesterday against infidelity as enunciated by R. G. Ingersoll. He criticised very severely Ingersoll's knowledge of the sciences, especially astronomy, geology, and geography, and remarked that if in his boyhood he had gone to school to a good teacher and manifested no greater proficiency in these branches the teacher would have said to him, "Go to the foot, Robert."

But I did not sit down to discuss theological matters, but only to say that I had been recreating by way of diversion from medicine. It may be presumed that even a doctor may need a little respite occasionally.

Since I came here I have seen two cases of mitral stenosis—at least two heart specimens. I had always considered this to be an infrequent affection, and still think so, unaccompanied with regurgitation. In these hearts the valves were very much contracted. I did not learn the immediate cause of death. The symptoms of stenosis as far as the circulation is concerned are very similar to those resulting from insufficiency of those valves. In both conditions the blood is turned back upon the lungs and through them upon the right side of the heart, producing hypertrophy with dilatation of the right ventricle with a great many other abnormalities. I saw one of these specimens at Bellevue, and the other was exhibited at the Pathological Society. Owing to their comparative rarity they were preserved.

Prof. Welch, in his lecture on pathology, exhibited a specimen from a woman who had embolus of the pulmonary artery, from which she died. This embolus was formed from a thrombus in the internal iliac vein, resulting from late parturition, which had occurred two weeks previously. She did well up to this time, having a slight metritis, which passed off in a few days; was supposed to be convalescing, was up, and would in a short time have been discharged from hospital had not this accident happened. It is supposed, as is commonly the case, that the plugs of coagula in the uterine veins at the site of the placenta had extended to their junction with the internal iliac, where a clot was washed off by the current in that vessel and carried on to the heart, and thence found its way into the pulmonary artery. Of course sudden death occurred from asphyxia. In all probability the slight attack of metritis occurring soon after confinement encouraged to some extent the prolongation of the uterine venous thrombi into the iliac vein. I have but little doubt, however, that if the patient had been kept quiet in bed for a week or so longer she would have escaped pulmonary embolus. I feel very confident that many cases of pneumonia die of heart-thrombus simply from getting up too soon. It is characteristic of some *patients* to be *impatient*, and restraint or confinement to bed in them in many instances is hard to accomplish. I well remember a very melancholy instance of this kind, and the only

one, I believe, I ever lost from heart-clot in pneumonia. I thought the patient had entered the stage of convalescence, the temperature having become normal and the physical signs denoting returning health. He, however, belonged to the restless, impatient class, and from frequent getting up a heart-clot formed and destroyed him suddenly, and, of course, entirely unexpectedly to both me and his friends. The main significance of this accident to the practitioner is in cases where there is a possibility of the formation of a thrombus to keep the patient in a state of absolute quietude.

A very singular case of mistaken diagnosis was made, a few days since, in a woman with hypertrophied spleen. This organ was mistaken for an ovarian tumor, and was corrected only *after* incision was made into the peritoneum. Of course the opening was at once closed and results awaited. The patient died in four days; but on examination of the organs post mortem it was found that she could have lived only a short time had not her case been mistaken for one of ovarian tumor. Aside from the spleen being quite large she had a cirrhosed liver much deformed in outline. The posterior border was quite thin, while the anterior was greatly thickened—in fact, the two borders apparently reversed as far as thickness was concerned. The gall-bladder was distorted and rested partially on the front border and upper surface. As a whole the liver was diminished in size from atrophy. The spleen was some four or five times its natural size, enlargement of which organ is common in cirrhosed liver. There also existed chronic inflammation of the stomach and intestines, producing thickening and deformity of these organs. With this condition there also existed peritoneal dropsy, which almost always accompanies cirrhosis of long standing. To cap the climax, with all the other pathological conditions, she was afflicted with *piles*. Now it can readily be seen that her chances for life were very slim *before* the peritoneal cavity was opened; but it may be said that this condition of the internal organs did not excuse the false diagnosis or even palliate it. It may be asked how such a mistake could be made in a case of enlarged spleen. This is a question hard to answer when we think of the proper situation of the organ. Even when enlarged to such an extent as to invade the right iliac fossa, it should not be mistaken for ovarian tumor, as it can be traced as a continuous body to its natural position in the left hypochondrium. A false diagnosis is excusable in cases of fibroid or carcinoma of the ovaries, but, I think, in enlargement of the spleen, never.

T. B. GREENLEY, M. D.

NEW YORK, Jan'y 18, 1882.

Formulary.

CEREBRAL SOFTENING AS A RESULT OF EMBOLUS.

Prof. William A. Hammond (Med. and Surg. Reporter), referring to the treatment of this affection, says:

The one great and grand thing to do when the patient is seen in the first stage of the attack is to *let him alone*. Merely keep the head slightly elevated and cool, and there stop. Later on, after the active symptoms of irritation, such as muscular twitchings and convulsions and the general prostration, have passed off, then the head should be kept warm, at an equable temperature, but not hot, so as to facilitate the flow of blood to the part. Otherwise simply carry out whatever indications may arise, such as drawing off the water if the bladder is paralyzed, or administering a cathartic if there is obstinate constipation. The diet should be nourishing and simple, and the habits regular. But if the strength continues to fail, and there appear symptoms of heart-weakness, the question as to whether stimulants should be given then arises. When such a crisis comes there is only one thing to do. Alcoholic stimulants must be administered carefully in small and repeated doses, and the effect closely watched. So the patient should be tided over the dangerous period until the vessels can recover their normal relations. But after all active symptoms have disappeared something should be done in the way of trying to improve the nutrition and power of the brain. Strychnia and phosphorus seem to have such an influence. One tenth of a grain of phosphate of zinc and one third of a grain of nux vomica may be given at a dose. The following is the usual formula:

℞ Zinci phosphatis..... gr. iij; 0.18 Gm.;
Ext. nucis vomicæ..... gr. x; 0.66 Gm.

Fiat pillulæ xxx.
Sig. One pill three times a day.

ANTISEPTIC PROPERTIES OF ESSENCE OF WINTERGREEN.

We see in the *Concours Médical* that Prof. Gosselin and Dr. Bergeron have experimented with oil or essence of gaultheria (*Gaultheria procumbens*)—wintergreen—and have obtained good results from it as an antiseptic in the dressing of sores.

Essence of wintergreen is much used in perfumery. It has an agreeable odor, and is insoluble in water but soluble in alcohol.

Two solutions are used by Prof. Gosselin:

Oil gaultheria.....	fl.℥ j½;	5.00 fl.Gm.;
Alcohol (60°).....	fl.℥ xijss;	50.00 fl.Gm.

Oil gaultheria..	fl.℥ ¾;	2.125 fl.Gm.;
Alcohol.....	fl.℥ iij–fl.℥ j;	12.00–30.00 fl.Gm.;
Water.....	fl.℥ xijss;	50.00 fl.Gm.

—*Med. and Surg. Reporter.*

Lectures.

THE PRE-CANCEROUS STAGE OF CANCER, AND THE IMPORTANCE OF EARLY OPERATIONS.—EMPIRICISM AND SPECIFICS.

Delivered at the London Hospital.

BY JONATHAN HUTCHINSON, F.R.C.S.,

Senior Surgeon to the Hospital; Consulting Surgeon to Moorfields Ophthalmic Hospital; Professor of Surgery and Pathology, Royal College of Surgeons.

Gentlemen: The patient who has just left the theater is the subject of cancer of the tongue in an advanced stage. As I demonstrated to you, the lymphatic glands are already enlarged. It is hopeless to think of an operation, and there is nothing before him but death, preceded and produced by a few months of great and continuous suffering. His case, I am sorry to say, is but an example of what is very common. Not a month passes but a case of cancer of the tongue presents itself in this condition. The cases which come while the disease is still restricted to the tongue itself are comparatively few; nor does this remark apply only to the tongue. "Too late! Too late!" is the sentence written but too legibly on three fourths of the cases of external cancer concerning which the operating surgeon is consulted. It is a most lamentable pity that it should be so; and the bitterest reflection of all is that usually a considerable part of the precious time which has been wasted has been passed under professional observation and illusory treatment. In the present instance the poor fellow has been three months in a large hospital, and a month under private care. I feel free, gentlemen, to speak openly on this matter, because my conscience is clear that I have never failed when opportunity offered, both here and elsewhere, to enforce the doctrine of the local origin of most forms of external or surgical cancer, and the paramount importance of early operation. I have tried every form of phraseology that I could devise as likely to impress this lesson. Nearly twenty years ago I spoke to your predecessors in this theater concerning the "successful cultivation of cancer," telling them how, if they wished their patients to die miserably of this disease they could easily bring it about. The suggestion was that all suspicious sores should be considered to be syphilitic, and treated internally by iodide of potassium, and locally by caustics till the diagnosis became clear. More recently I have often explained and enforced the doctrine of a pre-cancerous stage of cancer, in the hope that by its aid a better comprehension of the importance of adequate and early treatment might be obtained. According to this doctrine in most cases of cancer of the penis, lip, tongue, skin, etc. there is a stage—often a long one—during which a condition of chronic inflammation only is present, and upon this the cancerous process becomes engrafted. I feel quite sure that the fact is so. Phimosis and the consequent balanitis lead to cancer of the penis; the soot-wart becomes cancer of the scrotum; the pipe-sore passes into cancer of the lip; and the syphilitic leucoma of the tongue, which has existed in a quiet state for years at length in more advanced life takes on cancerous growth. The frequency with which old syphilitic sores become cancerous is very remarkable. On the tongue in particular cancer is almost always preceded by syphilis, and hence one of the commonest causes of error in diagnosis and procrastination in treatment. The surgeon diagnoses syphilis, the patient admits the charge, and iodide of potassium seems to do good; and thus months are allowed to slip by in a state of fools' paradise. The diagnosis, which was right at first, becomes in the end a fatal blunder, for the disease which was its subject has changed its nature. I repeat that it is not possible to exaggerate the clinical and social importance of this doctrine. A general acceptance of the belief that cancer usually has a pre-cancerous stage, and that this stage is the one in which operations ought to be performed would save many hundreds of lives every year. It would lead to the excision of all portions of epithelial or epidermic structure which have passed into a suspicious condition. Instead of looking on while the fire smouldered, and waiting till it blazed up, we should stamp it out upon the first suspicion. What is a man the worse if you have cut away a warty sore on his lip, and when you come to put sections under the microscope you find no nested cells? If you have removed a painful, hard-based ulcer of the tongue, and with it perhaps an eighth part of the organ, and when all is done, and the sore healed, a zealous pathological friend demonstrates to you that the ulcer is not cancerous, need your conscience be troubled? You have operated in the pre-cancerous stage, and you have probably effected a permanent cure of what would soon have become an incurable disease. I do not wish to offer any apology for carelessness, but I have not in this matter any fear of it.

EMPIRICISM AND SPECIFICS.

The patient whom we are about to discharge from Talbot ward, cured of severe pemphigus, was admitted for a special purpose. He was sent in by my friend and former pupil Dr. Tom Robinson, in order that he might be cured. You will say that the hope of cure is the motive which brings most of our patients to us. True; but in this instance there was something more than this. Dr. Robinson could have easily cured him himself, but he sent him here in order that I might do the miracle of cure under your eyes, and thus claim your belief in the efficacy of drugs. You will remember his state when admitted; he was covered from head to foot with bullæ; the trunk was less severely affected than his limbs, head, and genitals; on these there was nowhere a space as large as the palm free from bullæ, and on the trunk also there were a considerable number. He was in a miserable condition from pain and irritation. The eruption had been out about ten days, and it effected the mucous membrane of the mouth as well as the skin. You may remember that we kept him in bed for a few days before we used the magician's wand in order that all might see that there was no natural tendency to amelioration. More bullæ came out; then without making the slightest change in diet we ordered a few drops of a tasteless solution of arsenic to be swallowed three times a day. The result was that at our next visit most of the bullæ had dried, and there were no fresh ones. He continued to improve greatly for ten days, when suddenly a few fresh small bullæ seemed to threaten a relapse. We doubled the dose of our remedy, making the dose eight instead of four drops; and from that day with the most trifling exception the recovery has been uninterrupted. With such a fact before you let me beg of you, gentlemen, to believe in drugs, and to treat empiricism with re-

spect. In the prescription which I ordered I availed myself solely of empirical knowledge. I prescribed, just as any old woman might prescribe, that which I knew would do good. Concerning the nature of pemphigus I knew nothing; of its cause absolutely nothing; of its clinical relationship but little; of the *modus operandi* of arsenic I scarcely knew more; but I did know this as a fragment of assured conviction, that arsenic would cause the pemphigus eruption to disappear and the patient to regain his health. Far be it from me to speak slightingly of scientific work; let us by all means work as hard as we can in the laboratory and microscope-room, and penetrate as far as we possibly can into the mysteries of disease; let us never weary in our search after causes, or in our endeavor to find practical application for the facts of physiology. But while doing this let us remember that as regards the relief of suffering much of our usefulness must be based upon knowledge which is nowise scientific, but simply a matter of experience and memory. We have many specifics for many maladies, or rather for many symptoms, and he is the most successful practitioner who has stored in his memory the largest number of them. In time we shall add many more to our list, and I doubt not that there are those who now listen to me who are destined to give help in their discovery; for discoveries in this direction are rarely made by single observers, but rather by the concurrent work of many experimenters, all keeping their eyes open, willing to try new things, and resolute to store faithfully the results of their observations. Iodide of potassium for tertiary syphilis, the bromide for epilepsy, and as an anaphrodisiac, iodoform for phagedena and specific ulceration, balsam of Peru for scabies; so silently have these invaluable specifics been introduced into practice that it would puzzle most of us to say who first recommended them. I mention this fact in order to show how important is the honest labor of all in the pursuit of therapeutics. We all prescribe, and we ought all, on system, to observe and record the results of our observation as to the effect of drugs. Five and twenty years ago I believe that the case of pemphigus which you have seen cured would have been found incurable in all the medical institutions of the world, with one single exception. Much more recently than that the disease was pronounced by Hebra to be invariably fatal. So indeed it would have been to this day if we had not found out arsenic. I know of nothing else that will cure it. Our patient was already beginning to emaciate, and in the course of a few months—possibly of a few weeks—he would have had to die, worn out by the constant discharge from his skin, had we not put arsenic into his blood. Never shall I forget seeing a poor wretched child carried on a bed into Mr. Startin's out-patient room at the Blackfriar's Hospital for Skin-diseases. It had been brought straight from the wards of one of our largest hospitals, where during three months all had been done for its help that benevolence, aided by the science of the day, could suggest. Yet it was emaciated to skin and bone, and so covered with sores that it was impossible to put its clothes on. A few minims of arsenic were prescribed, and in a few weeks the child was well. So much for empirical knowledge; so much for drug-specifics.—*British Medical Journal.*

THERE were no deaths from smallpox last week in Louisville.

Miscellany.

MECHANISM OF FORCEPS-LABOR AND THE PRINCIPLES OF FORCEPS-CONSTRUCTION.—Dr. W. H. Studley, of New York, advances the view, in the American Journal of Med. Sciences for January, 1882, that the doctrine generally taught that the fetal head enters the superior strait in a direction corresponding to a line drawn perpendicular to its plane is erroneous; and the evil influence which this view has exerted on the manipulation of the obstetric forceps has resulted often in most disastrous consequences. Dr. Studley believes that the head does not enter the superior strait in a line with its axis, but in one that cuts it at quite an angle, and that the general pelvic axis is a line departing from the axis of the superior strait in a posterior direction instead of an anterior one, and that therefore the practice hitherto followed of varying the handles pubicward from the moment the head enters the pelvic excavation until its exit is one which not only materially frustrates the accoucheur's efforts but endangers the mother and child. According to Dr. Studley, traction should be made in a direction fifteen or twenty degrees posterior to the axis of the superior strait until the pelvic floor is reached, and in no wise should the tractions be varied in a direction anterior to that axis until extension of the head shows that the pelvic floor has been reached. This part of forceps-labor, Dr. Studley thinks, is attended with as many if not more difficulties and dangers than that which brings the head from the superior strait to the bony pelvic floor; and singular as it may seem he regards these dangers and difficulties as lying in an exactly opposite direction to that usually urged by the books and teachers. The anxiety hitherto manifested has been in regard to the danger threatening the integrity of the perineum by making tractions in the perineal direction. To avoid this a strenuous warning has been urged to elevate the handles too early rather than too late; and the result has been in but too many instances that the head has been turned out by a prying, lever process, inflicting not only perineal laceration—just the danger sought to be avoided—but contused wounds of the pubic arcade which has served as a fulcrum for the forceps shanks, and cuts of the vagina, and in some instances of the ischio and pubio-coccygeus muscles by the posterior-end edges of the blades. If the forceps have well-fitting

blades, and the head is snugly held by them, it is easy to see how, by such a maneuver the top of the occiput is made to hitch under and against the pubic arch as a pivotal point, and the forehead and the face to forcibly sweep out by a long radius against all the soft parts anterior to the coccyx.

Dr. Studley also describes an obstetric forceps made after his own design, which is somewhat similar to Tarnier's in that he has borrowed from Tarnier the perineal curve and binding bar, yet their action is based on entirely different principles.

REDUCING FRACTURES WITHOUT PAIN AND WITHOUT ANESTHETICS.—By A. S. Hudson, M.D. (Med. and Surg. Reporter):

Many years ago, R. W., a boy of fourteen years of age, fell and experienced a fractured arm. It proved a Colles fracture. Splints were applied and held in place by ties of strong tape. In four weeks, to all appearance, the limb was restored to symmetry and health. The dressings were removed and the arm and hand were slowly brought into everyday use.

A week later my attention was called to it. To my mortification there stared at me all the original deformity seen at the moment of the accident. What had happened? Nothing! The lad used it as he found occasion, and with no particular occupation. Gradually the bony displacement had returned in mockery of chirurgical therapeutics. The injury was now five weeks old. What was to be done? We have all heard of broken limbs in malposition being purposely broken over again. Such a course seemed irrational, indefensible, and, therefore, unsurgical. The splints were re-applied. This time, to the outside board of a cigar-box was nailed an infra piece at right angles with the side piece; this basic splint was as wide as the thickness of the arm, to sustain the weight of the forearm and hand and afford barely sufficient border to support the lower edge of the inside splint. The whole was tied firmly with two tapes and supported in a sling. It was dressed and tightened up every one or two days. The weight of the hand and the gradual, painless pressure of the splints slowly corrected the ugly, abnormal features, and in two weeks it was a satisfaction to witness all deformity gone and the member restored to natural shape. The mistake was in removing the splints prematurely.

Aside from recovering lost ground without harm, this case furnished important instruction and outlined a new and better rule of practice. It taught how to dress fractures without inflicting pain and without the use of anesthetics. It taught how to dispense with what the writer now regards as the absurd proceeding of *pulling the injured part to "set the bones."* That old, first step is agonizing and needless. If splint-pressure and position of limb will painlessly reduce fracture and deformity after five weeks' existence, why not employ them for that object in the outset and avoid the flourish of setting, garnished with screams? The simplest and easiest is the best. Therefore, for more than a decade, every case of fractured arm in my hands has been dressed in the manner above described, without pulling, without pain, without chloroform or ether, and without resulting deformity. With daily dressing, in a few days or a week apposition of the fragments is gradually and insensibly effected. As the swelling subsides the natural contour of the member is brought about all in ample time. As a general rule bandages to fractured limbs should be condemned and avoided. But the subject of absurd bandaging is sufficient for another article.

THE paper of Prof. Diehl, of the Louisville College of Pharmacy, should be read with attention. He maintains that emulsions are easy to make, and describes his process in detail. We have had samples made by his working formula on the shelf for some time, and can vouch for their palatability and permanence. They are certainly equal, if not superior, to any proprietary specimens yet exhibited. There is no reason why the country doctor should not make his own emulsions from materials the purity of which he can determine for himself.

HYSTERIA IN CHILDHOOD.—Schmitt (*Ann. Univ. di Med. et Chir.*) confirms the existence of hysteria in children, as is admitted by numerous authors, and reports several cases seen in the clinic at Strasbourg: 1. A case of hysterical aphonia in a little girl aged seven years, and cured by the simple introduction of the laryngoscope. 2. A case of a little girl, thirteen years of age, who had not yet menstruated, and who had for nine months been unable to swallow; she was cured by a single catheterization. 3. A case of an anemic and badly-nourished little girl, aged nine years, with convulsive and maniacal hysteria which resisted all treatment. 4. A case of a little girl nine years old, who had a hysterical contracture and

was cured by moral treatment. As causes of this rare disease, the author indicates anemia, chlorosis, and inherited nervous temperament. The general condition of the patient must be improved before any treatment is attempted.—*Medical News.*

ANEURISM OF THE PULMONARY ARTERIES.—The statistics of aneurism of the pulmonary artery, as collected by Dr. John F. Duffield, of New York, and published in the American Journal of Med. Sciences for January, 1882, show that only eleven cases have been as yet reported. To these Dr. Duffield now adds a twelfth, occurring in the wards of the New York Presbyterian Hospital, and of which he gives the clinical history with a careful description of the lesions as revealed by post-mortem examination.

Selections.

A Novel Mode of Applying Plaster-of-Paris Bandages.—By W. Newman, M.D. Lond., F.R.C.S. Eng., Surgeon to the Stamford Infirmary (Brit. Med. Journal):

The material employed is a coarse-meshed book-muslin. A piece of this of sufficient length is taken and folded into a long bandage, having from sixteen to twenty-four thicknesses of the material, according to the requirement of the special case, and varying in width from two to three fingers' breadth. It is desirable, the folds being so numerous, that a loose thread-tacking should be run along the free edges, to preserve the shape of the bandage and provide against unfolding. Before proceeding further the bandage should be soaked for a few minutes in water, so as to remove the stiffening or glaze which is liberally introduced in the process of manufacture of the material. The plaster of Paris should be mixed with water (an equal bulk of each seems to be the most satisfactory proportion), in a large, rather shallow bowl. A mixture of creamy consistence will be the result. Into this mixture the bandage, prepared as above, must be placed and quietly molded or kneaded, so that every part of it may be thoroughly permeated with the compound. It may be very loosely rolled up from each end toward the center, for convenience of using.

It will render the further description more easy if the reader will think of the bandage thus prepared as affording at the pleasure of the surgeon either a narrow but thick band, or when opened out by removal of the basting-thread, a flattened, much wider or expanded portion.

The narrower portion of the bandage permits application in simple ring or in figure-of-eight fashion around the terminal part of the fractured limb; and the wider expanded portion, carried upward on the sides of the limb, furnishes a perfectly firm and well-molded support to the injured part. A layer of wadding may be placed round the limb, so as to secure any projecting point from undue pressure before the bandage is applied; or most commonly it will be found sufficient to rub the limb over with a fairly thick coating of oil or simple ointment. The plaster bandage will then not adhere to the skin.

The Mode of Application in Simple Fractures of the Forearm. The arm, as is usual, must be placed in position between pronation and supination, and extension must be kept up so as to maintain the fractured ends of the bones in their proper relation one to the other. The middle of the bandage is applied to the front of, and then round, the wrist-joint. A ring is formed in this way, embracing firmly the lower end of the radius. One end of the bandage is now carried from behind between the thumb and finger, and downward in its expanded portion over the anterior face of the forearm; while the other half of the bandage is taken directly from the ring over the wrist upward over the posterior surface of the forearm. Two long but narrow and rather strong bits of wood are now applied, one on each face of the forearm, with tolerable firmness; and a few turns of tarlatan bandage, *without plaster*, must be applied over these, to keep the whole framework in place until the drying and hardening of the plaster be fully completed. The advantage from these temporary wooden splints is that the middle portion in length of each expanded portion is thus bent inward, so as to correspond to the normal interval between the radius and ulna.

If there be simple fracture through the carpal end of the radius the encircling ring is placed round the hand over the metacarpo-phalangeal joints; and the molding of the wider portions of the bandage is commenced almost at once, so as to give support to the point of injury. When the plaster is perfectly firm the outer encircling bandage and the wooden splints are removed. A simple tie, elastic or other, will then suffice if placed round the arm not far from the elbow, to keep the plaster framework in close apposition to the limb.

If simple fracture of the fibula, or of the tibia and fibula, transverse, and without tendency to displacement, be in question, the bandage, prepared as above, is at once put on. The middle and narrow portion of the bandage is placed to correspond with the lower third of the leg posteriorly; the ends are brought round in front, and a complete close-fitting ring is so made; then they are brought down, each one over the corresponding malleolus, and crossed beneath the foot; finishing finally by the close application of the expanded portions, one on each side of the limb, nearly or quite up to the head of the tibia. The best rule for the width of these expanded portions seems to be that in the midline, both anteriorly and posteriorly, a vacant space of two fingers' breadth should be left between the corresponding edges of the plaster bandage.

Should the fracture of the leg be oblique, with more or less of riding and displacement, an ingenious adaptation of the plaster bandage is employed. To the leg itself a plaster bandage, as above named, is applied, with this variation only, that before the crossing of the narrow portion is made beneath the foot, a roll of bandage is placed in close contact with the sole, and over this the crossing is managed. When the plaster has set the bandage is taken away, and a projecting yet quite firm stirrup is left beyond the foot. This plaster bandage, so-called "extenseur," is covered with a layer of oil or simple ointment, and then an outside framework is arranged. A long bandage is taken, soaked in plaster as directed. Between the layers a short piece of wood is slipped to make an

outer stirrup about three inches below that attached to the leg. The bandage is carried up outside the leg on each side to a point above the knee, and each side-prolongation is stiffened by the insertion of a piece of wood of the required length. The ends of the bandage are wound round the lower third of the thigh, so forming a complete ring, and inclosing the upper ends of the lateral wooden supports. This appliance is known as the "center-extenseur."

The coating of oil or grease prevents any adhesion of the two bandages at the points where they are in contact. To complete the fixing when the plaster shall have thoroughly set the two stirrups, superior or foot attachment, and the inferior or outer framework, are tied together by a band of strong elastic. The extension so obtained will maintain the fractured ends of tibia and fibula in their proper place.

M. Dumont has applied plaster bandages on the above principles to cases of morbus coxarius; to fractures of the thigh, leg, and arm, simple and compound; and to cases of joint-disease when extension or absolute fixation is desirable, with an unvarying good result. . . .

The especial advantages which may fairly be claimed for this mode of using plaster of Paris may thus be summed up: There is no covering up of the fracture or injured joint. The support, with proper care in the application, is abundantly firm from the first moment; secondary displacement, even with a restless patient, is impossible. The materials are inexpensive, and not difficult of use. The need for complicated apparatus in the treatment of the majority of fractures is done away with; and the comfort and convenience, especially to those of us who practice in the country, will be found to be very great.

Chian Turpentine in Uterine Cancer.—Dr. W. Brown writes to the Lancet: I read with great interest Prof. Clay's account of his experience of the effect of Chian turpentine in the treatment of uterine cancer. At the time when Prof. Clay first drew attention to the use of this drug I was house-surgeon to the General Infirmary at Leeds, and we at once commenced to administer the remedy according to the instructions laid down in his paper, but I am sorry to say the results were not such as those described by Dr. Clay. Out of eight cases (to each of which the drug was given while the patients were inside the hospital) not one showed any signs of improvement. Two or three mended slightly in general health, but that was most probably due to the nursing and food and the thorough cleanliness, etc. At any rate the same improvement is noticed in those who are not taking any medicine at all, and therefore I think we may fairly attribute the change to improved surroundings rather than the specific action of the drug. That every one is only too ready to adopt any means by which we can alleviate the sufferings of patients the victims of malignant disease I think Dr. Clay will allow, and it is but fair to assume that the drug he praises will have had a full and unbiased trial throughout the land. Nowhere does there seem to be an echoing of the glad tidings which he proclaimed a short time ago, and which last week he followed up by more illustrations. Why is this? A remedy such as this ought surely to be as efficacious in one man's hands as another, and yet so far as I know no one has borne testimony to the value of the drug in question save the introducer, while many have written and told of its failure. The only reason which seems at all likely to account for this discrepancy in result may, I think, be gathered from the following fact—the number of cases treated. In a general hospital like the Leeds Infirmary we got together eight cases in six months, whereas from a special hospital and from private sources Dr. Clay only meets with nine in two years. Now this can only mean one of two things—either Dr. Clay is particularly fortunate in not meeting with uterine cancer, or that his nomenclature for this form of disease differs from that of the profession generally.

Laughing-gas as an Anesthetic During Labor.—In a paper recently published in the *Archiv für Gynäkologie* Dr. Stanislaus Klikowitsch, of St. Petersburg, advocates the use of nitrous oxide for the purpose of obtaining anesthesia during labor. He has employed a mixture of four parts of nitrous oxide and one of oxygen, kept and supplied under a sufficient pressure to make its density the same as that of atmospheric air. The author has a miniature gasometer in which he stores it; for obstetric purposes he carries it in an india-rubber bag which he puts under the pillow of the patient. The advantages which he claims for it are the following: 1. Its use is quite free from danger either to mother or child, and it has no unfavorable effect in prolonging labor, contrasting in this respect advantageously with chloroform. 2. It without doubt does away with pain in all the stages of labor. 3. By means of this mixture complete anesthesia can be obtained without loss of consciousness, and therefore without diminishing the action of the voluntary muscles; the fullest possible power is thus available for the expulsion of the child. 4. Absence of vomiting, and often, if vomiting has begun, relief to this symptom; absence also of any period of excitement, and of the after-consequences of anesthetics—nausea, headache, dyspepsia, etc. 5. The anesthesia can be continued throughout the whole period of labor, without any cumulative effect; since during the intervals of pain the effect of the preceding inhalations completely passes off. 6. The presence of the medical man is not indispensably necessary for the administration of this anesthetic. The chief objections to the use for this purpose of nitrous oxide are its comparative costliness and that the gas and the necessary apparatus are not so portable as could be desired. We should be inclined to dissent from the statement which the author puts sixth in his list of advantages.—*Med. Times and Gazette.*

Case of Epilepsy Produced by Reflex Irritation.—The following is from the St. Louis Courier of Medicine: "W. S., a boy aged eleven years, had been suffering from epileptic attacks for several years, which came on at different periods. The boy was rather emaciated and of very nervous temperament. On examining the boy's penis I found he had phimosis, with a very small preputial opening. He told me that sometimes when urinating the prepuce swelled up by the urine which collected, and could not empty as fast as it came from the urethra, causing him some pain, which, however, he never told his parents. I then advised the parents to have the boy circumcised, which would materially help, if not entirely cure, this terrible disease of their son. They consented. The next day I performed the operation, having the patient under the influence of chloroform. The wound healed without trouble. From that day his nervousness grew less and less; he has had no other attacks; to day, one year and a half after the operation, he is stout and fleshy.

Excision of the Knee in Early Life.—From a paper on this subject Dr. William Stokes draws the following conclusions:

1. Excision of the knee should not be looked on as a last resource, but should be undertaken, if possible, before any profound organic changes take place.

2. Expectant treatment, to be efficient, must be undertaken at an early stage of the disease, and extend over a period of at least two years.

3. No better result than ankylosis can be looked for by this method.

4. In a patient with a predisposition to secondary tuberculosis developments the possibility of the recurrence of the disease after expectant treatment must be borne in mind.

5. In cases attended with prolonged suppuration the chances of the occurrence of visceral, especially renal disease, must not be lost sight of.

6. Where the skin is unbroken, the disease limited, an efficient method of fixation applied, and a rigid system of antiseptic dressing of the wound adopted, primary union may in the majority of cases be anticipated.

7. When these latter conditions are fulfilled excision of the knee-joint can not be longer regarded as the formidable procedure it was formerly held to be.

8. The alleged unfavorable results of excision of the knee-joint in early life are opposed to more extended clinical experience.—*British Med. Journal.*

Electrolysis for Epilation.—The battery used by Dr. Heitzmann consisted of sixteen cells. At first the action of the galvanic current was very slow, due to an insufficient moistening of the sponge, which the patient held in her hand. If the sponge was kept well soaked in water, six or even five cells were sufficient to render the operation successful and almost painless. The needle attached to the negative pole was inserted into the hair pouch, without touching the hair itself, so that the negative pole was applied to the bottom of the hair pouch, the positive, by the sponge, to the hand. A whitish discoloration around the needle, detached epidermis, a little frothing, and subsequently a marked redness around the needle occurred. The loosened hair was then removed (without any force) by tweezers; the root was slightly discolored and looked as if burned through. A second insertion of the needle into the gaping pouch is advisable. A small papule or pustule follows the operation, which will heal up without leaving any scar worthy of note. Failures will occasionally occur, but Dr. Heitzmann operated upon four hundred and fifty hairs, and six months afterward only six hairs had recurred, which readily yielded to a short operation. —*Med. and Surg. Reporter.*

Sudden Dislocation of the Liver—Recovery.—Dr. A. Y. P. Garnett (Amer. Jour. of the Medical Sciences) reports a case of sudden dislocation of the liver. A lady, aged fifty, while stooping down hurriedly to pick something from the floor felt a sudden wrench or giving away on the right side. Examination revealed a displaced liver reaching to the crest of the ilium. Much discomfort was experienced, but the patient was relieved by spontaneous reduction in the space of three days. A week's confinement in bed, followed by the use of a broad elastic band around the waist, constituted the necessary remaining treatment. The patient apparently regained to a great extent her normal condition and state of health.

Dr. Schæffer on Ozena.—Ozena, according to Prof. Max Schæffer, is nearly always the result of scrofula or of syphilis. It may be due, however, though rarely, to a primary affection of the bones or cartilage. He distinguishes two stages of the affection, a hypertrophic and an atrophic. In the former the secretion is abundant, thick, and creamy, and forms thick crusts, especially in the naso-pharynx. The crusts when detached give rise to hemorrhages, and leave behind them erosions, which are liable to run on to superficial or deep ulceration. The mucous membrane is livid, thickened, and pits on pressure. In the atrophic stage the secretion is less abundant, more fluid and viscid, and forms fine crusts, its capacity being due to the admixture of epithelium. The mucous membrane is pale, thin, and very adherent to the bones, and undergoes fibroid degeneration, while the glands are destroyed. The spongy bones are atrophied, and the meatus on each side is considerably enlarged. When due to hereditary syphilis the ozena is frequently developed during the first weeks of life, the hypertrophic stage in these cases lasting eight to ten years. The duration is the same when scrofula is the cause. In acquired syphilis the stage lasts from six months to a year. Here the affection begins in the periosteum and cartilage of the bone. The author recommends injections of chlorate of potash to be used twice a day, and in the intervals he introduces, in the atrophic stages, plugs of cotton wool. He condemns the use of carbolic acid, and says that in cases cured by its use smell is permanently lost. Constitutionally he employs the usual remedies.—*London Med. Record.*

Bresgen on Chronic Catarrh of the Nasal Fossæ and Pharynx.—Dr. Bresgen (*Annales des Maladies du Larynx, etc.*) enumerates the causes of this affection as frequent colds, enlarged tonsils, elongated uvula, abuse of tobacco, snuff, and the vitiated atmosphere of warm rooms. Syphilis, he says, is not a cause, as it only affects the nose when it is previously the seat of catarrh. Among the symptoms he insists on the importance of bleeding and redness of the nose as certain signs of commencing chronic rhinitis. His treatment consists in the insufflation of powdered nitrate of silver and starch (from 0.5 to 10 per cent), and in obstinate cases he applies the galvano-cautery. He seldom resorts to injections, except in cases attended with much fetor, and condemns the use of the plug recommended by Gottstein. To facilitate the inspection of the posterior nares he inserts the index finger of the left hand—preferring it to the hook of Voltolini—to draw the palate forward. To overcome the hyperesthesia of the palate, fauces, etc. frequently present Dr. Bresgen paints the parts with iodide of glycerin (iodide 0.5 to .1, iodide of potassium 2.5 to 5, glycerin 25), and affirms that in three applications a sufficient degree of insensibility is obtained. During these applications the patient is forbidden the use of tobacco, alcoholic drinks, and strongly-spiced food.—*London Medical Record.*

Boracic Acid in Fetid Sweating.—Dr. George Thin speaks in the highest terms, in the Practitioner for December, 1881, of the use of boracic acid in cases of offensive sweating of the feet. He employs a solution of boric acid in glycerin incorporated with a fatty basis of white wax and almond oil; this gives a soft homogeneous cream, free from all irritating crystalline plates and quite permanent.—*Med. News.*

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